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Reflexivity and habitus in young people's use of the internet for health information

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ABSTRACT In Ulrich Beck's writings on the 'risk society' he depicts contemporary western social identity as reflexive and ad hoc – shaped through calculative strategies of self-management rather than traditional social categories such as class. Beck's model of 'reflexive individualization' can be seen to be particularly pertinent to the realm of health today, which is increasingly marked by discourses of the 'DIY' subject. This article uses the findings of a study of young people's use of online health information as a means of examining the utility of Beck's theories. Comparing the experiences of young people from different social backgrounds, the article complicates the assertion that social identity has broken free of its class affiliations. Adopting the term 'health habitus', the article suggests that one way of countering the problematic tendency in Beck's work to displace questions of social location is to ground the notion of reflexive individualization in Bourdieu's concept of habitus.

KEYWORDS *Beck, health habitus, internet, online health information, reflexive individualization, risk society, youth*

Introduction

Over the past decade the writings of the German social theorist Ulrich Beck – in particular his book *Risk Society*, which was first published in Germany in 1986 and translated into English in 1992 – have played a pivotal role in shaping debates in the West over the nature of late modernity and contemporary social identity.[1] Beck's work has offered up nothing less than a new sociological vocabulary, one aimed at shedding light on the complex transitional processes that he sees western societies currently experiencing.[2] In *Risk Society*, for example, he contends that there has been a 'break within modernity' whereby the modernization process has turned upon itself and become what he terms 'reflexive modernization' (Beck, 1992: 9). A key feature of reflexive modernization is the shift from

a preoccupation with managing wealth and its (unequal) distribution to a preoccupation with managing risk, here 'defined as a *systematic way of dealing with hazards and insecurities induced and introduced by modernization itself*' (Beck, 1992: 21; emphasis in original).

Of central concern to this article is Beck's (1998) argument that the experience of external risk and reflexivity is now a *generalized* experience that cuts across social divides and has been accompanied by a shift to a new, individualized form of social identity. By individualization Beck means 'first, the disembedding and, second, the re-embedding of industrial society ways of life by new ones, in which individuals must produce, stage and cobble together their biographies themselves' (1994: 13). In other words, people's personal biographies are becoming freed from their attachment to the fixed categories of social identity such as social class, family, gender or occupation that once marked modernity. This shift towards reflexive individualization means that choice becomes central to people's existence as their identities are formed increasingly through lifestyle-oriented decision-making. Accordingly, 'class biographies, which are somehow ascribed, become transformed into reflexive biographies which depend on the decisions of the actor' (Beck, 1992: 88).

One of the key areas where Beck's theories of risk, reflexivity and individualization are particularly relevant is in the realm of health. The past couple of decades of post-welfare, neo-liberal political 'reform' in countries such as Australia has seen a broad reconceptualization of citizens as self-managing, 'enterprising individuals' (Rose, 1996). In the arena of health this has been accompanied by a reframing of personal health management as a lifestyle choice. Thus health promotion discourse is concerned decreasingly with government responsibility for morbidity or mortality statistics, focusing instead on questions of individual responsibility (Higgs, 1998) and on the body as a central site where questions of personal ethics and the social good are played out (Beck and Beck-Gernsheim, 2002). This shift has seen population health strategies and policies shift increasingly from a more structural, macro-social approach to a model that emphasizes the need for individuals to engage directly with their own health status. The ideal enterprising citizen in this latter paradigm is one who actively monitors, regulates and manages their own health (with the help of appropriate expert advice and knowledge) as part of a broader project of rationalized lifestyle management.

A number of major studies over the past couple of years have shown that a significant proportion of people in developed nations now regularly access health information online, a development that could be seen as an archetypal act of self-management and a kind of democratization or universalization of the values of autonomy and self-care (Fox and Fallows, 2003; Rideout, 2001; Taylor, 2002). Beck's notion of reflexive individualization would appear to be a highly appropriate critical tool for conceptualizing the way that many lay people increasingly are using

new media technologies as a means of accessing health expertise and, in turn, managing their own health biographies.

The article that follows discusses the findings of a study into young people's use of the internet for health information, focusing in particular on young people's perceptions and use of medical expertise and their degree of investment in individualistic conceptions of health. The premise of the study was that within the broader population of health-oriented, do-it-yourself (DIY) citizens, young people are likely to be particularly reflexive consumers of online health information. As a group associated both with high rates of internet use and a tendency to avoid dealing with the 'mainstream' medical system, the internet would seem to offer a relatively easy way of anonymously accessing a wide range of lay and 'expert' health and medical information – information which in turn could be easily tailored to a young person's specific 'lifestyle needs' as an active health consumer.

At the same time, given the impact and wide acceptance of Beck's theories of risk and reflexivity within the realm of health (Bunton et al., 1995; Lupton, 1995; Petersen and Bunton, 1997; Scambler and Higgs, 1998),[3] the study was concerned with critically assessing the claim that the shift to reflexive modes of selfhood has been accompanied by a decline in the relevance of traditional social categories. The study asks the question: to what extent and in what ways are we now reflexive subjects? And is the call to reflexivity experienced differently by different social subjects? Beck's analysis of contemporary identity has been criticized for failing to take into account the ways in which social inequities are not only ongoing today, but are potentially intensified in a political and cultural environment that emphasizes freedom of choice and enterprising modes of selfhood over social-structural understandings of the social self (Skeggs, 2002). As Skeggs suggests, rather than representing the dissolution of social categories, the discourse of reflexivity in fact may disguise an intensification of processes of distinction marked by a growing gap between those 'who cannot access and utilize reflexivity as a cultural resource' and those for whom 'reflexivity is a tool by which the resourceful self is produced' (2002: 365).

Dovetailing with this critique, the findings of the study indicate that while the notion of reflexive individualization offers insights into conceptualizing the pressures on young people to be healthy self-managing citizens, reflexive identity is not necessarily experienced evenly or in the same manner across different social groups. Instead, the study suggests that the social dispositions or habitus associated with different social locations continue to play an important role in framing young people's perceptions and experiences of reflexive health consumption. Drawing upon an expanded conception of Bourdieu's notion of habitus – as an embodied cultural formation that is both structuring, in that it 'organizes practices and perceptions of practices', and is itself structured, 'as a product of internalization of the division into social classes' (1984: 170) – the article concludes by arguing that, in conceptualizing and managing themselves

as healthy and/or at-risk bodies, the young people in the study bring to bear a surprising range of different cultural frames or forms of 'health habitus' to the task of reflexive self-care. It is suggested that these varied experiences indicate a need to move away from a universalizing model of reflexivity, which is often reflective of a narrowly middle-class model of identity and cultural value, and instead to 'specify' the different experiences of reflexivity associated with different social locations.

Method

From mid-2003 to mid-2004, in-depth interviews were conducted with 19 young people aged between 17 and 25. In order to explore the way in which social location and habitus might be articulated to different modes and experiences of reflexive social identity and DIY models of health, half of the sample was drawn from the University of Melbourne undergraduate student population and the other half from a city branch of the Melbourne Citymission, a charitable organization which provides help through its 'Frontyard' youth service to young people aged between 12 and 25 years who are homeless or in need of support. The University of Melbourne is a prestigious 'sandstone' university located in inner urban Melbourne, which traditionally has drawn its student base from an educated middle class élite largely based in the eastern suburbs of Melbourne. During recent years, this student demographic has shifted somewhat to incorporate full fee-paying international (particularly South-East Asian) students, although the majority of interviewees in the sample were from Anglo-European backgrounds. While the interviewees were not specifically asked questions about their social location or identification, it was hypothesized that the University of Melbourne students were likely to come from middle-class backgrounds and would exhibit some shared assumptions and values in relation to questions of health and self-care.

In contrast, individuals from the Citymission hailed from relatively disadvantaged social backgrounds and were expected to bring a rather different set of social experiences and cultural values to the question of individual reflexivity around health issues.[4] Given the issue of low internet access for the Citymission group, who were often either homeless or living in squats or transitional housing, people were specifically recruited to the study who were using a free internet service offered on weekdays by the Frontyard service. The internet service was offered on a drop-in, voluntary basis. Of the nine young people recruited through the Citymission, five of the participants were male and four were female. All were Australian-born from Anglo-European backgrounds. The University of Melbourne group consisted of six females and four males. While four people in the group were born overseas (two were from Malaysia, one was Indonesian and one was

born in Germany) they had all lived for significant periods in Australia. The rest were Australian-born and of Anglo-European ethnicity.

All of the interviews were conducted individually. Interviews were semi-structured and focused around the following topics:

- health issues of concern to the participants;
- whether they used the internet for health information and how they critically assessed that information;
- their perceptions of the role and status of doctors and use of medical expertise; and
- whether and in what ways they conceived of themselves as reflexive, self-managing health consumers.

In the process of encouraging the participants to talk about health issues, the establishment of a rigid definition of health or health information was avoided. Instead, the interest focused on what this group of young people included under these broad umbrella terms. The wide range of answers received indicated a variety of definitions, from more narrowly medical understandings to much broader 'lifestyle' approaches to health that focused on diet, exercise and general 'bodily maintenance'.

The object of the study was to capture a sense of the major discourses that participants drew upon in narrativizing their approaches to health maintenance in their daily lives and whether or how questions of social location impinged upon the way in which they constructed their health biographies. Here it should be noted that in discussing questions of social difference in relation to the university students and the Citymission youth interviewed, the primary goal of the study was not to provide a generalizable, objectivist account of the relations between class, youth and the consumption of online health material. Rather, the study was concerned with gauging at a more qualitative level the major discourses framing individual ideas about personal health and how these discourses played out against people's actual life experiences and opportunities, their sense of potentialities and risks, and their feelings of control (or lack thereof) over their health and their own life paths.

Discussion

Online health consumption and the role and status of medical expertise

A key aspect of Beck's thesis regarding risk and reflexivity is the crucial role played by scientific expertise. To be a healthy, responsible subject under reflexive modernity, one has to weigh up the risks and benefits of certain actions and behaviours: that is, to exhibit a kind of calculative rationality in relation to assessing what kind of lifestyle one is going to live. Crucial

to the process of making informed decisions about risk management and lifestyle choice is the mediating role of the expert. However, a central premise of Beck's notion of the risk society is that science, technology and 'progress' have become objects of extreme ambivalence so that that the status of the expert is now rather fraught. An awareness of the hazards and risks produced and often actively covered up by the scientific community in the name of industrial productivity is now a pervasive part of daily life in developed nations. Links between industrial pollution and insidious forms of illness are denied along scientific grounds while ordinary people are forced to become 'alternative experts in risks of modernization' in order to contest such claims (Beck, 1994: 61). As Anthony Giddens puts it, while science was once 'invested with the authority of a final court of appeal', in today's risk society it 'has lost a good deal of the aura of authority it once had' (1994: 87). However, while there is a pervasive scepticism towards expertise, at the same time people are becoming increasingly reliant on the abstracted knowledge possessed by experts as life becomes defined by a growing sense of complexity and insecurity. Thus the contradictory position of scientific expertise, as Beck characterizes it, is that while science has contributed to creating the risks that mark everyday life in reflexive modernity, it also offers itself up as the means of understanding and therefore managing these same risks.

In this study one of the themes of particular interest for examination was the relationship between young people's perceptions of, and reliance on, doctors and medical expertise, their use of the web for health material and their sense of themselves as reflexive self-managing health consumers. International studies indicate that large numbers of people are taking their health management into their own hands and accessing health information directly via the internet. Two recent quantitative surveys indicate that up to half of all adults in the United States have used the web for health information (Fox and Fallows, 2003; Taylor, 2002), while one of these surveys similarly found high rates of online health consumption in France, Germany and Japan (Taylor, 2002). In relation to youth as a subgroup of health consumers, a large study entitled Generation Rx.com (conducted by a philanthropic group in the US) found that out of 90 percent of young people who had gone online, more than two-thirds had accessed some health information while a quarter had sourced a lot of web-based health material (Rideout, 2001). In the present study, all of the participants were regular internet users and most had looked up health information on the internet at some point. Eight of the 19 young people accessed online health information on a reasonably regular basis, suggesting a highly active and reflexive approach to health management.

Only two people out of the 19 interviewed had never used the internet for health information and both of them were very internet-savvy. In the case of Paula, a 20-year-old arts student, this was not due to a lack of interest in health but to a sense of the lack of legitimacy of the internet

compared with face-to-face contact with a doctor. As Paula answered when asked if she looked up online health information:

> No, not really, not for stuff like that [health information] 'cos sometimes I'm a little concerned that they're not . . . legitimate . . . I think you will still need some kind of personal touch. I mean, I think you can get a lot of information off it and you can use that to your advantage, but personally I wouldn't feel comfortable with just that. I'd want that and a professional opinion as well.

Indeed, while most of the young people had accessed health information from the internet this activity definitely was not seen as a replacement for seeing a doctor, although it was used at times to supplement the information that their doctor had given them or to access information that they felt their doctor could not (or would not) tell them. As a number of larger quantitative studies have shown, rather than replacing contact with western medical practitioners, by and large people are using online health information to supplement their visits to the doctor (Fox and Fallows, 2003). However, while online health consumers are still using the mainstream medical system, the question that needs to be asked is whether the 'democratization' of medical knowledge via the web is having any impact on the role and status of medical practitioners. Accordingly, in this study the participants were asked how they perceived their doctors compared with how their parents might have seen them. While the doctor was once seen as the first port of call for health issues, what role did they see the doctor as having today? Were they just a service provider, like a hairdresser, or were they seen as offering something more?

The majority of study participants still perceived doctors as having relatively high status compared with other health service providers, with their authority being seen to be specifically linked to the long period of study that doctors undertake and their grounding in western science. However, for these young people, the perceived high status of doctors was less about social standing and more about efficacy and the scientific legitimacy associated with a medical degree. This perception of efficacy alongside a continued faith in scientific knowledge meant that almost all of the interviewees saw doctors as the first port of call during an acute illness. As Amy, a 19-year-old girl from the Citymission, put it when asked whether she had ever used alternative medicine: 'I probably wouldn't go to like a naturopath or anything like that . . . I trust my western medicine.'

However, while western medicine was seen as possessing continued authority, a number of the young people qualified their statements about the status of doctors by noting that the growing number of different types of health experts available made doctors seem less 'special'. Others observed that the availability of health information on the web meant that doctors no longer had sole control over medical knowledge. While both the university students and the Citymission group had access to free, on-site health services (and also often to a family doctor), they seemed

to have little investment in forming an ongoing relationship with a sole general practitioner (GP). Instead, most of them did not have a regular GP and either attended whatever medical service was available at the time or talked about the need to 'shop around' for a decent doctor. Overall there was a sense, particularly among the university students, of relying first on themselves to maintain their own health, with the doctor being seen as a back-up option. As Sarah, a 20-year-old female arts student, says:

> I don't think doctors are people you go to . . . for a broader sense of health. Like if you're sick you'll go to the doctor and find out about it, but to know how to maintain health I don't think doctors are the main source.

For the most part then, the study participants did display what might be described as a self-consciously calculative and strategic approach to the use of doctors. While doctors were seen as still having a privileged status as medical experts, the young people themselves often drove health decisions rather than relying solely on medical practitioners. In other words, there was a sense that doctors have a kind of technical rather than pastoral status for many of the young people. While a couple of the study participants had family GPs who they saw as central to both their own and their family's health decision-making, for many of the young people, doctors were perceived instead as useful strategic resources for managing their personal health.

While doctors tended to be their preferred source of medical information, as previously noted, many of the young people interviewed also accessed health information on the internet. For example, for the interviewees from the Citymission in particular, web-based health information on the side-effects of prescription medications was seen as a way of accessing more information than they might have got from their doctor. Two of the girls from the Citymission also talked of using online health information as a way of empowering themselves when dealing with their medical practitioners.

While most of the young people had looked up health information on the web, however, many were wary of much of the information available because it was seen as a medium where 'just anyone' could put up their opinions. While a couple of the young people expressed an interest in being able to access other people's accounts of their experiences with health and illness, most of the study participants expressed a preference for expert rather than lay forms of medical knowledge. The following comment was typical:

> I think you have to be careful 'cos anyone can write stuff and put it on the internet and it'll come up in a search engine. So we would have to be careful what we read and what we take to heart and follow. (Rachel, 21, media studies student)

Supporting Beck's argument that scientific expertise has become essential to daily life at the same time as it is being relatively demystified,

most of the young people in this study were active consumers of health information who, by and large, exhibited a degree of scepticism about the source and validity of this information, particularly in relation to the internet. However, Beck's claim that 'the power gradient' between 'modernity and tradition, experts and lay people' (1992: 165) is flattening out under reflexive modernity seems more problematic. For the most part, the participants expressed a strong preference for biomedical rather than alternative or lay forms of knowledge. In relation to choice of health practitioners, for example, surprisingly few of the participants had been to a 'natural' or 'alternative' therapist, with many of the young people expressing distrust in the efficacy of non-western medical approaches. As previously noted, when asked about the credibility of health material on the web, most of the young people expressed a strong preference for, and trust in, expert rather than lay forms of knowledge.

This perspective is reflected in much of the media coverage of the issue of online health information. Rather than embracing the web's potential to 'democratize' knowledge, newspaper coverage has tended to adopt a tone of panic in relation to lay people (or 'cyberchondriacs' as they were referred to in an article in the *Independent*; Bee, 2004) accessing health information via the web. Often, concern is raised about the lack of regulation of the material available on the internet and the idea that people might be seeking medical information from the internet rather than going straight to their doctor.

In the context of this ongoing faith in biomedical expertise, Beck's claim that in reflexive modernity '[s]cience becomes indispensable and at the same time devoid of its original validity claims' (1992: 165) suggests an overreading of the public 'crisis' of science and rationality. Instead, the prevailing faith in biomedicine expressed by most of the young people in this study and their reliance on scientific modes of expertise suggests both an extension of scientific rationality into everyday life and a continued belief in its core principles. As Anthony Elliott succinctly puts it: 'the idea of "risk society" is thus bound up with the development of instrumental rational control, which the process of modernization promotes in all spheres of life' (2002: 295).

However, as will be discussed in the next section, while most of the young people exhibited a concern with accessing health information and expertise as a means of managing their health, the participants did not all access the same kinds of expertise, neither did they make use of medical and health systems and sources of information in the same way. Arguably, this suggests that the pluralization of knowledge and expertise in the risk society involves not so much a relativization of rationality and thereby a weakening of its core claims, but instead the emergence of multiple rationalities attuned to different aspects of everyday life.

As Simon Cottle points out, it is also important to recognize here the complex interchange between expert, scientific knowledge and 'cultural

and hermeneutic' forms of knowledge or 'social rationalities' (1998: 14–15); a dimension which, he points out, is underplayed in Beck's work. Thus, while the young people in this study generally professed a preference for 'scientific' forms of medical knowledge, the types of medical and health information they defined as fitting into the category of scientific rationality differed considerably depending on individual conceptions of what constitutes a 'health issue'. Furthermore, how they applied that knowledge in their daily lives – that is, what they considered to be a 'rational' or strategic approach to their own health care – was framed by rather different sets of cultural competencies, values or forms of what could be termed 'health habitus'. In other words, the young people exhibited more than one mode of rationality or reflexivity in relation to perceived imperatives to self-care and these modes tended to be broadly related to socio-economic (and gendered) forms of identity.[5]

Specifying the reflexive health consumer

Whether obtaining information from the internet or accessing it directly from a doctor, it could be said that for the most part the participants exhibited a remarkably reflexive approach to medical and health expertise, drawing strategically upon those forms of knowledge and professional help that were seen as relevant to, and useful for, their particular personal needs. As Frank, a 22-year-old from the Citymission commented in relation to searching for the latest information on treatments for hepatitis C:

> there's too much broad-ranging information for hep[atitis] C and it's too controversial . . . you can read through an article on one website and then go to another website and it'll say the entirely opposite . . . I just go through and read things up and think, OK, this has got this and this from here and there, and this one's got some references to this site . . . Comparing information and trials and stuff like that.

While Frank was one of the more enthusiastic web users in the study, the young people interviewed generally saw themselves as capable of weighing up and critically assessing different forms of medical and health information. At first glance, there was a sense that these young people felt they had a degree of agency in managing their own health and that they conceived of their bodies and themselves as 'projects' to be managed. A crucial aspect of conceiving one's life in terms of a 'reflexive biography', however, is the production and maintenance of oneself as a responsible healthy citizen. One of the central issues for examination here was the way in which the young people were aware of, and the degree to which they measured themselves against, a broader public ideal of the healthy reflexive citizen. Thus, in addition to asking the participants about their use of health information, they were asked what it means to be healthy today, what their regimes of health and bodily maintenance and self-management entailed, whether they were aware of broader community

imperatives around public and personal health maintenance and how this awareness had an impact on their own approaches to health.

In the discussion with the young people across both groups, many exhibited a strong awareness of discourses of health promotion and self-management, linking their own personal health to broader community health issues such as the increasing rates of obesity in Australia (a topic that had received a large amount of recent media coverage). There was a pervasive sense of measuring oneself against a healthy ideal, to which many of the young people saw themselves as not matching up. When asked if she was healthy, Joanna, a 19-year-old female science student who described herself as looking up information on healthy eating and exercise on the internet once a week, reading regularly about health issues in magazines and newspapers and as a regular taker of vitamins, said: 'Um, I don't think I'm healthy, I'm not sure but I don't think I'm healthy . . . Maybe I may lack some nutrition . . . my nutrition may be not balanced.'

In assessing the degree to which they measured up to more idealized conceptions of the 'healthy subject', it was here that clear distinctions started to form between the two groups of young people in relation to their values and perceptions of health norms and what they considered to be 'rational' health behaviour. Like Joanna, most of the university students talked about health maintenance in terms of monitoring their exercise regimes and dietary intake. Keeping slim and fit was not merely seen in terms of body image – although that was a major driver – it was also seen as an investment in one's health biography as this comment from Diane, a, 20-year-old arts student, illustrates:

> I think it's important to eat well and exercise . . . I've got a friend who doesn't do anything, doesn't do exercise. She's not overweight or anything so it's not a big issue now, but I was reading in a magazine or a newspaper article or something that not doing exercise can equate to the same as having cancer in terms of how bad it is for your body.

The youth at the Citymission also were generally conscious of public discourses around health maintenance and preventative health, and often talked of the problems associated with junk food and the need to keep fit. However, when questioned more closely about what they defined as a healthy diet or what it means to be 'fit', their constructions of a healthy lifestyle often clashed with more normative community ideals of reflexive risk minimization. For example, many described themselves as being 'fit and healthy' at the same time as they admitted to being regular smokers (one young woman who was an overweight smoker described herself as a 'health freak').

In a discussion of risk and reflexivity, Giddens (1991) argues that people who indulge in risky behaviours despite knowing the risks often are living out the notion of 'lifestyle' as a package of risks. For these people, risky behaviour is tolerable within an overall lifestyle choice; according

to Giddens, such risk behaviour is underpinned by a reflexive awareness that they are refusing to adapt to the risk-reduction lifestyle. However, such a construction of reflexivity and risk tends to assume that individuals are fully conscious and in control of their decision-making processes; reflexivity here is seen as a process of considered reflection where an array of life choices are weighed up against each other. Furthermore, both Giddens' and Beck's model of reflexivity assumes that risks are external and objective rather than being individually or culturally defined or influenced by social context.

The findings in this study suggest that while many of the young people constructed their health biographies according to a language of lifestyle and self-care, for many of the Citymission youth there was often a lack of fit between these public discourses of autonomy and choice and their cultural values and life circumstances. These narratives of responsible, healthy selfhood often sat rather uncomfortably with life narratives that were marked by a sense of unmanageable risk and lack of control over both oneself and one's environment. A classic example came from Joe, an 18-year-old at the Citymission who had developed an eating disorder brought on by the stress of living in a very chaotic home situation. In describing his problems with eating, Joe tended to use the language of self-actualization both to narrativize and take control of his situation:

> After my 17th birthday, I mean only a year and a bit ago, I sat down and thought to myself: this isn't going to be easy, but I have to do something. I'm not happy with my . . . emotional or physical self, I've got to do something. So I did a chart: this is what I eat, this is what I don't eat, this is how much I eat.

For Joe, attempting to frame himself within the model of the self-monitoring healthy subject seemed to offer a way of managing the chaos of his life. However, in reality, Joe found himself increasingly losing control over his weight as he oscillated between bouts of overeating and periods of anorexia. Rather than empowering him to deal with a rather dire social situation, the ideal of reflexive identity contributed to an internalization of his broader social and family problems, here manifested as a pathological obsession with food intake. When translated into the individualized, psychologized terms of reflexivity, Joe is cast as a failed reflexive agent. Here we see the gap between the life experiences of the middle-class educated subject – the specific form of habitus privileged in the idealized model of reflexive individualization – and those of other social groups for whom the 'choices' associated with the notion of 'reflexivity' are framed by a rather different set of social, cultural and material contexts and constraints.

This sense of the way in which different life experiences and forms of health habitus produce distinct modes of reflexivity was highlighted particularly by the manner in which the participants discussed their

management of risk. While most participants discussed the need to manage external health risks, a sense of risk and insecurity around personal health was particularly marked among the young people from the Citymission. The university students at times discussed potential risks to their health. However, they framed these largely in terms of preventable factors internal to their own lifestyles, e.g. diet and exercise. Thus while they went to doctors when they were sick, they talked about health largely in preventive non-medical terms, as something intrinsic to their broader lifestyles and therefore primarily self-managed. A good example of this was Derek, a 21-year-old education student, who described how he used the web to access the exercise regime of his favourite Australian Rules football team:

> Well, actually [my concept of health] . . . it's more again about fitness. I've looked up . . . I follow Essendon in the footy and I looked up their website and they actually put up, their fitness coach puts up their pre-season, everything that they do. So I've actually printed that out to sort of look at it and try to do some of that . . . it was interesting to know the amount of stuff they do but also see how much I could do.

By contrast, the young people from the Citymission spoke of risk in more externalized terms; the fear of diseases, particularly infectious diseases such as hepatitis C, the effects of drug use and developing diseases that were 'in the family' such as diabetes, featured strongly in their health narratives. For example, this quote from Jane, a 17-year-old, reflects a health habitus oriented towards potential disease risk:

> Yeah, I always use the internet 'cos, like, I've lost a few of my mates . . . like a lot of my mates did stupid things and ended up getting . . . unwanted things. Like one of my mates ended up with AIDS and died . . . a few of my mates also have hep[atitis] B, so we were, like, curious, so we hopped on the net on the library and looked up all stuff on that and found out a lot of stuff 'cos the doctor wouldn't explain to us.

The largely medical focus of their health concerns means that attempts to 'take control' of one's health tend to translate into a heavy reliance on doctors and other experts and support provided through state institutions. Paul, a 21-year-old at the Citymission, described his regime of bodily maintenance as follows:

> I go for check-ups every few months . . . Just make sure everything's all right . . . I generally go to the hospital, wait for a few hours . . . Just standard blood tests, skin tests, dental check-ups . . . should I need it.

Another example of this tendency to perceive (and experience) risk in external terms was the fact that, even though all of the Citymission young people were smokers (compared to none of the university students), smoking was never discussed as a health risk. While they were aware of anti-smoking health promotion discourse, most of the Citymission interviewees

seemed to see their own smoking as an inevitable part of life rather than as something that could or should be managed or controlled.

This mode of health self-management is certainly very different from that of the middle-class university student proactively monitoring their diet and exercise regime. Both of course can be described as moments of reflexive individualization, but here we see a classic example of the way in which this umbrella term tends to gloss over the ongoing contribution played by social identity in framing the boundaries of any one individual's reflexive biography. For example, the mode of reflexivity exhibited by the Citymission youth was one marked by a strong sense of uncontrollable external threats combined with a certain degree of fatalism and/or habituation in relation to issues such as smoking and drug use. In contrast, the university students experienced themselves by and large as being 'in control' of both their health and their broader life biographies. Seldom referring to external risks, they largely saw health reflexivity in terms of individual self-management – although it should be noted that, in some cases, this translated into an element of anxiety that they might fail to match up to broader health ideals, while for others in the group, self-care was seen as an issue that could be put on hold for now and managed at some later date when they were older and it became more of a concern.

In all, these findings both support and greatly complicate Beck's claims that social life today is driven by processes of reflexive individualization where 'the standard biography becomes a chosen biography or "do-it-yourself biography"' (1994: 15). Certainly, in relation to medical and health expertise, whether accessed via a doctor or the internet, the participants tended to use expert forms of knowledge in a pragmatic and strategic manner. This strategic approach to expertise fitted in with a broader conception of health and health maintenance as an issue to be managed by the individual rather than the broader community. Whether framed in terms of exercise and nutrition or the management or prevention of particular diseases, on the surface these young people's reflexive awareness and continual self-monitoring of potential health risks seemed to affirm Beck's depiction of today's society as a world of calculable risks and self-managed biographies.

However, where the findings begin to complicate this picture is in pointing to the ways in which people's actual material experiences of risk and reflexivity as well as their perceptions and practices of self-management are often markedly different. This article will conclude with a discussion of the limitations of Beck's conception of social identity as post-traditional and the need to link the notion of reflexivity more strongly to questions of social position and cultural value.

Conclusion: habitus and reflexivity

It has been suggested that part of the problem with Beck's model of reflexive individualization lies in its assumption that the social subject is

an essentially rational, calculative self (Petersen and Bunton, 1997). And certainly, Beck (in a book on individualization co-written with Elisabeth Beck-Gernsheim) sums up the new post-traditional social order as a place where '[i]ndividuals become actors, builders, jugglers, stage managers of their own biographies and identities and also of their social links and networks' (Beck and Beck-Gernsheim, 2002: 23). In other words, in contrast to the fragmented subject of postmodernity, the reflexive self aims to map out a coherent consistent narrative of identity through constantly weighing up and assessing one's lifestyle choices. Such a construction of the self does seem to support a rather instrumentalist and voluntarist model of social identity. However, while it is true that Beck's work often lapses into a kind of instrumental-rationalist mode, it is important to acknowledge his consistent attempts to counter these tendencies. Thus, for example, in his essay in *Reflexive Modernization*, Beck is at pains to point out that the process of individualization is not free-floating, cut away from its ties to the social, rather it represents a new form of sociality that is not voluntarist but socially prescribed and institutionalized. As he neatly sums it up, '[i]ndividualization is a compulsion' (Beck, 1994: 14).

As has been emphasized in this article, however, a crucial (but less examined) problem with Beck's work is its tendency to universalize the experience of one particular mode of reflexive individualization. While reflexive modernization may be marked by a compulsion to map out one's path as an autonomous individual, surely (as the findings here would suggest) such forces are experienced unevenly and responded to in very different ways across social space. The question becomes one of whose kind of experience of the social world is best captured by the notion of the reflexive subject, as it is played out in Beck's work. In an interview published in 2001, Beck was asked to comment on the relevance of 'cosmopolitanism' to sociology today. Noting the rise of globalization and the need for sociology to shift its focus away from the nation-state, he remarked rather glibly that '[p]eople now work internationally, they love internationally, they marry internationally, they bring up children internationally' (Boyne and Beck, 2001: 47). The flexible, mobile cosmopolitan subject assumed here is the same reflexive subject around which much of Beck's work on risk and reflexivity tends to revolve – that is, a rather privileged one. Beck's throwaway line marks a broader tendency in his work to generalize the experiences of this group of bourgeois cosmopolitans.

This is not to suggest that Beck's writings are devoid of any discussions of issues of social inequality. As he notes in relation to reflexive individualization, '[i]ndividualization has never meant the dissolution of social inequality, but so far always its *intensification*' (Beck, 1998: 35; emphasis in original). Such statements indicate a degree of recognition by Beck that, even in what he sees as a 'post-class' setting, the notion of reflexive individualization does need to be grounded in an analysis of social hierarchy and power. However, Beck does not carry these insights through into the

totality of his work in any systematic way. Instead, the default mode of his work is to talk about risk and reflexivity in a rather undifferentiated fashion. All of this is not to discount his useful thesis concerning the centrality of reflexive individualization, but rather to suggest that his picture of social identity today is a profoundly partial one. A systematic reworking of Beck's account to address questions of power and domination is beyond the scope of this article. However, one way in which it has tried to suggest that Beck's account might be usefully supplemented and strengthened is through combining his notion of reflexive individualization with Bourdieu's concept of habitus.

Scott Lash has pointed already to the utility of Bourdieu's reflexive sociology for conceptualizing the relationship between class and what he terms the 'aesthetic' or cultural aspect of reflexivity. In his essay in *Reflexive Modernization* on 'Reflexivity and its Doubles', Lash (1994) argues that what tends to be left out of discussions of reflexive modernization is the role played by everyday or ordinary culture. He contends that while class and community may be ascribed no longer in a structural sense, they continue to shape social identity through shared sets of cultural values. Thus the use of the term 'health habitus' in this article has represented an attempt to foreground the continuing role played by issues of cultural value and social hierarchy in shaping experiences of embodied, reflexive selfhood. This translates into internalized socio-economic differences in both health perceptions and practices as well as different levels of cultural capital or 'competence in cultural codes' (Frow, 1995: 31), in terms of matching up to the ideal of the healthy self-managing citizen.

A model of reflexivity grounded in the notion of habitus captures the way in which individual experiences of health and illness are structured by an individual's life biography, material circumstances, cultural values, habits and practices as well as by broader institutional and social contexts. Issues of power and domination enter the picture through the ways in which certain forms of cultural capital are valued over others in health discourse. As previously noted, for example, in the realm of public health there has been a shift towards privileging middle-class cultural values of individualism and rationality as a kind of normative ideal towards which we should all strive. As Skeggs (2005) has argued, the working classes face the double bind of being constructed as incapable of 'playing the game' while their responses to their own material experiences often are dismissed or seen as pathological. However, the young people from the Citymission (most of whom could be characterized as members of a working class or underclass) demonstrated modes of reflexivity that both negotiated and challenged middle-class norms. That is, they showed an ability to both play the game (albeit with limited resources) and demonstrated that there were other games with other rules. Managing health, for example, was often as much about community support and family networks as it was about more individualized models of self-care. This is not to romanticize

the experiences of a group of young people who were clearly disadvantaged at a number of levels, but to foreground the limitations of the narrow model of reflexivity circulating within Beck's work and within much reflexivity discourse.

To sum up, Beck's (2002) argument that sociology must stop holding onto 'zombie categories' such as class is fundamentally flawed in its failure to recognize that while social identity today is strongly marked by discourses of individualization, class and other social differences continue to structure people's experiences within reflexive modernity in elemental ways. Indeed, as individuals experience growing pressure to transform themselves into entrepreneurial, DIY subjects, the links between the possession of certain forms of socially-valued cultural capital and social hierarchy are heightened rather than diminished. Beck's dismissal of class as an organizing principle is not only premature but demonstrates a failure to recognize his own role in legitimating a specific set of middle-class experiences as somehow broadly representative of the community at large. In the process he fails to identify the degree to which his own account of reflexive individualization dovetails with neo-liberal discourses of individual self-management and empowerment; discourses that work to efface ongoing systematic inequalities in the name of competitive individualism. While Beck's risk paradigm is surely crucial in that it points to the growing centrality of the role of individualization today in processes of governmentality, without a fundamental analysis of power and social inequality in the global risk society, the reflexive modernization thesis is incomplete both as a piece of descriptive political sociology and as 'a new and optimistic model of our times' (1999: 152).

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Notes

1. Beck's account of risk has struck a chord not only with academics working across a large range of disciplines (with risk and its various social and cultural manifestations becoming a major field of research in its own right) but also with a broader public that includes policymakers (Alexander, 1996).
2. It should be noted here that Beck's writings on risk and reflexivity have developed in concert with the work of other theorists of reflexive modernization, particularly Anthony Giddens and Scott Lash. While the scope of this article does not allow me to discuss the work of either theorist in any great depth, it is important to acknowledge the significant contribution that both writers have made to the broader debates on risk, reflexivity and post-traditionalism.

3. The concept of risk in particular has come to play an important role in both academic debates within health sociology and the formulation of health promotion and public health policy strategies.
4. While there were, for the most part, clear distinctions between the socio-economic status and education levels of the youths in the two groups, obviously it would be problematic to read these two groups as mirroring some simple middle/working class dichotomy. My use of the term 'social location' here is less concerned with a rigid notion of 'class belonging' than with capturing a broader sense of social identity as relational and contested and as encompassing a range of forms of social identity. Thus, although this article focuses largely on the way in which reflexivity is framed by questions of socioeconomic background, more broadly in the study, habitus is seen as being articulated not only to 'class' but also to gender and cultural background.
5. I found that gender played a significant role in shaping the health habitus of these young people. However, due to space limitations, the primary focus in this article is on social position as it relates to class (while recognizing as a matter of course the complex ways in which class experience is articulated to gender).

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